

Cover Sheet

**Managed Care Organization (MCO) Disclosure Compliance Package
Under the Physician Incentive Regulation
Submitted to Health Care Financing Administration (HCFA)**

for the Medicare + Choice Applicant

Name of MCO _____

Medicare Contract #H _____ PIP applies to Medicare+Choice applicants
(except for PFFS and non-network MSA)

**MCO is owned/controlled by a Federally Qualified Health Center or Rural Health
Clinic (FQHC/RHC) or consortium of FQHC/RHCs or includes FQHC/RHCs in its
network:**

YES _____ ; **NO** _____

Printed Name of MCO Contact Person _____

Phone # _____

**This represents our organization's disclosure compliance package submitted to HCFA or
SMA. I certify that the information made in this disclosure is true, complete and current to
the best of my knowledge, information and belief and is made in good faith.**

Printed Name of CEO _____

Signature of CEO _____ **Date:** _____

**Note: Please include this Cover Sheet as the first page of the MCO
Disclosure Compliance Package.**

PHYSICIAN INCENTIVE PLAN DISCLOSURE FORM FOR M+C APPLICANTS

Managed Care Organization (MCO) Name: _____
 Medicare Contract Number: H _____ Reporting year: _____

Note: Disclosure is required even if risk or substantial risk is not being transferred or panel exceeds 25,000.

CHECK ONE - Use this Disclosure Form to disclose the incentive arrangement between the first party (in the list below) that contracts with a second party (underlined on list below) for services to the MCO's Medicare (or Medicaid) enrollees. **Be sure to disclose subcontracting arrangements down to physician levels.**

-- Repeat forms as many times as needed to capture the various levels of contractual relationships.¹

-- For simplicity, "provider" is used here to refer to the second party. See instructions for completing this Form under "Single or aggregate disclosure" for aggregating either the first or second party.²

-- The HCFA Provider Data Worksheet can be the basis for this summary form. All forms and instructions are available at: www.hcfa.gov/medicare/physincp/pip-info.htm

- (1) _____ MCO to physician group (2) _____ MCO to intermediate entity
 (3) _____ MCO to individual physician (4) _____ Intermediate entity to physician group
 (5) _____ Intermediate entity to physician (6) _____ Physician group to physician group
 (7) _____ Physician group to physician (8) _____ Physician to physician
 (9) _____ Intermediate entity to intermediate entity

1. Provider(s) named or counted should be the underlined provider in the line checked above.

A. Name or Identifier of Provider: _____
 Use the actual name or any identifier for the entity or aggregated entities disclosed on this chart.

B. Number of Providers in the category selected: _____
 Give # of providers who are aggregated on this form; e.g., if this form is for physician groups, category #1, then give the # of physician groups; groups can be aggregated if risk arrangements are substantially the same and stop loss requirements are the same.

1. C. Is provider an FQHC/RHC? Yes _____; No _____
 If providers are aggregated, see instructions for disclosing FQHCs.

1. D. If #7 above is selected, give number of physicians who are:
Members (e.g. owners, employees) of the group # _____; **Contracted with the group** # _____
 These numbers must equal the number of physicians given in I.B.

NOTE: If either #2 or #9 is checked above, this form is complete since stop loss requirements do not apply to intermediate entities (IE). However, be sure to complete disclosures for the IE's relationships with provider groups and their physicians (#4 and #7) and with individual physicians (#5) because stop loss requirements apply to these levels.

2. Is risk transferred to the provider? Yes _____; No _____

Note: A bonus for low utilization of referral services is considered to be risk transference.
 If YES, check all the risk transfer methods with the provider and go to question 3.

Capitation _____; Bonus _____; Withhold _____; Percent of Premium _____; Other _____

Note: Consider the obligation for the provider to fund deficits as a "withhold".

Describe briefly:

PIP disclosure: MCO Name _____

3. Is risk transferred for referrals? **Yes** _____; **No** _____

Note: A bonus for low utilization of hospital, specialist or other services is considered to be at risk for referral services.

If NO, this chart is finished. If YES, proceed to next question.

4. Check all the referral risk transfer methods with the provider and go to question 5.

Capitation _____; **Bonus** _____; **Withhold** _____; **Percent of Premium** _____; **Other** _____

Note: Consider the obligation for the provider to fund deficits as a "withhold".

If needed, describe briefly:

5. What percent of the total potential payment is at risk for referrals: _____%

If above 25% proceed to question 6; if 25% or below you have completed this disclosure.

6. Number of MCO patients served by the provider **or** the number of pooled patients, if patients can be pooled (see criteria for pooling in the instructions). Check one category:

A __ 1-1,000; **B** __ 1,001-5,000; **C** __ 5,001-8,000; **D** __ 8,001-10,000; **E** __ 10,001- 25,000; **F** __ 25,000+

If number is 25,000 or below, answer #7. If the number exceeds 25,000, you have completed this disclosure.

7. State the type and amount of stop loss insuring the physician group and/or physician:

Aggregate insurance is excess loss coverage that accumulates based on total costs of the entire population for which they are at risk and which reimburses after the expected total cost exceeds a pre-determined level.

Individual insurance is where a specific provider excess loss accumulates based on per member per year claims.

Type: **Aggregate** _____; **Individual** _____; **Other** _____ [describe below if aggregate or other]

If individual [based on costs per patient], enter threshold/deductible amount: [enter only one amount]

Threshold: **Professional** \$ _____; **Institutional** \$ _____; **Combined** \$ _____

Describe if needed:

PUBLIC REPORTING BURDEN (FOR MANAGED CARE ORGANIZATIONS)"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0700. The time required to complete this information collection is estimated to average 100 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503."

¹For example, if #1 for the MCO to physician group is checked on one form, then use a separate form and check #7 to disclose the physician group's arrangement with its physicians.

²You must correctly represent the hierarchy of contracting and subcontracting relationships. For example, if you select # 1, you should aggregate all physician groups you contract with that have substantially the same incentive arrangements and stop-loss requirements. Then, on a separate form, you should select #7 to enter the physician group-physician arrangements only for the physicians associated with those provider groups. These related disclosures should be stapled together.